Chapter 10

OTHER SCHOOL HEALTH SERVICES

Case Management

Child Abuse

Referrals to Child Protective Services

Referrals to Other Health Care Providers

Nursing Liaison Services to Homebound Students

Case Management

Case management is "a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes." [1] These standards address the primary functions of case management: assessment, planning, facilitation, advocacy; and include standards for assessment, case identification and selection, problem identification, planning, monitoring, evaluation, and outcomes [2]. Although case management has been practiced for years, the discipline has expanded because it is has proven to be effective in maintaining high standards of care at minimum costs.[3]

Case management is a service model that focuses on assessment of needs and planning a continuum of care for students and families. Case management is intrinsic to the school nurse's job. School nurses function in the roles of community liaison, interpreter to school personnel, direct care provider, student advocate, and educator to students, families, and school personnel. It is the position of the National Association of School Nurses that the school nurse should have the knowledge and skills necessary to be an effective case manager[4]. This includes but is not limited to the following:

- Being knowledgeable about services available to students and families;
- Collaborating on a service plan based on professional standards of care;
- Coordinating continuity of health and related services;
- Assisting students and families to understand, select, and obtain health-related services;
- Evaluating the service outcomes for the attainment of medical, emotional, social, and educational goals[5].

Additional aspects of case management include:

- Being familiar with the various settings in which healthcare is delivered, the type of care available, and match it to the needs of the client – emergency, acute, transitional, subacute, specialized, chronic, or custodial care; and

- Remaining current about changes in federal and state legislation, and to recognize their impact on the healthcare delivery system and the options available for each client.[6]

School nurses naturally function as liaisons between healthcare providers, parents, and school staff. Many school nurses have functioned in the role of case manager for many years without describing what they do as case management. The new emphasis on case management formalizes and structures this role. Specific outcomes are predicted when case management is effective and these may include:

- Managing and teaching self care
- Continuity of care
- Reduced absenteeism
- Utilization of appropriate resources
- Collaborative interdisciplinary care
- Cost containment
- Meeting the physical, psychological, and emotional needs of children experiencing a chronic health problem in the school setting.[7]

> … case management focuses on empowering patients, giving them and their families access to a greater understanding of their disability or disease, a larger voice in the delivery of their care, and more personalized attention to their particular needs, enabling informed decisions and helping to deal with the complexities of the system.[8]

The nurse case manger is in a key position not only to address the needs of those served, but also to continually strive for better ways to assure the development of healthcare systems that will meet the needs of the future.[9]

Currently TDH is attempting to increase the number of healthcare providers engaged in case management for chronically ill children. Through THSteps Medical Case Management, TDH is encouraging professionals who work with children with chronic illnesses to become case managers for these children. School nurses who would like to work with this program will be reimbursed through Medicaid for each child that receives case management. The mission of THSteps Medical Case Management, within the

Bureau of Children's Health and the Division of Genetic Screening and Case Management, is to provide equal access to all services necessary for each THSteps (Texas Health Steps formerly known as EPSDT) recipients to have an opportunity to develop and maintain his or her maximum progress toward age- appropriate development, health, wellness, and educational pursuits[10].

THSteps Medical Case Management[11]

Who can be a provider?	**What is medical case management?**
Agencies or individuals who employ or are: ▪ Texas-licensed registered nurses or social workers, with a bachelors degree; and ▪ Providers of preventative, primary, and tertiary health and health related services or ▪ have written letters of agreement documenting referral relationships with providers of these services; ▪ and have a minimum of one year pediatric education and/or work experience in accordance with TDH policy; & ▪ be approved by TDH; and Attend TDH provided training on THSteps Medical Case Management	Services provided to assist eligible recipients in gaining access to medically necessary medical, social, educational, and other services aimed at: ▪ Reducing morbidity and mortality; and encouraging the use of cost- effective health and health-related care and ▪ Ensuring referrals to appropriate healthcare providers and ▪ Preventing inappropriate utilization or duplication of services.
Who Can Receive THSteps Medical Case Management?	**How Do You Apply To Be a THSteps Medical Case Management Provider?**
Children who are: ▪ One year up to 21 years of age (children from 0-1y) are eligible and are eligible and are served by Targeted Case Management Providers for High Risk Pregnant Women and High Risk Infants, TCM/PWI); & ▪ Medicaid Eligible in Texas; and ▪ Diagnosed with a health condition/health risk or special health care need, or identified as medically complex or medically fragile.	Contact TDH for an application: THSteps Medical Case Management services, contact Margaret Bruch, L.M.S.W.-A.C.P., at (512) 458-7111, Ext. 3045 or E-Mail

Nurses who provide case management for children need to be aware of state programs for children with chronic health care needs. TDH's largest non-Medicaid program for

CSHCN is the Chronically Ill and Disabled Children's Program (CIDC), which has provided services to CSHCN since the 1930s. CIDC uses state and federal funds to pay for medical care and related services for CSHCN whose families' incomes are too high to qualify for Medicaid but not sufficient to cover extraordinary medical costs. CIDC Client Support Services pays for physician services, hospitalization, durable medical equipment and supplies, physical and occupational therapy, speech-language pathology, and other services for over 10,000 Texas children who have a covered diagnosis and who meet financial guidelines. CIDC also supports case management services for CSHCN in all 11 public health regions. Families who need assistance finding information about TDH programs for CSHCN or about other state and local programs for which they may qualify can call a special TDH Babylove toll-free hotline (1-800-422-2956)[12]

Child Abuse

Child abuse means physically hurting a child, sexually molesting a child, failing to provide proper care, or depriving a child of support and affection[13]. Many children are at risk for, or suffer, physical, emotional, or sexual abuse or neglect. Research indicates that as many as one out of every four children will be the victim of sexual abuse. Very young children as well as older teenagers are victimized. Almost all of these children will be abused by someone they know and trust: a relative, family friend, or caretaker.[14] The teacher or school nurse may be the only adults outside the family who have contact with these children on a regular basis and, are professionally and legally obligated to intervene by reporting cases of suspected abuse to the appropriate authorities.[15] For this reason it is important for all school personnel to be familiar with:

- Reasons for abuse, types of abuse, and those at particular risk for abuse;
- The legal responsibilities for reporting actual proof of or suspicion of abuse;
- The method for reporting (including that which is specific to the particular school division where the individual is employed); and
- Resources available for the individual reporting the abuse and the individual being subjected to the abuse.[16]

Operational Definitions of Abuse

Physical Abuse

Physical abuse is defined as any act, whether intentional or not, that causes harm to a child. Intentional physical injury usually is related to severe corporal punishment; however, physical abuse ranges from minor cuts and bruises to severe neurologic trauma and death.[17]

Physical Neglect

Physical neglect occurs when caretakers do not provide for a child's physical survival needs (including adequate food, clothing, shelter, hygiene, supervision, and medical and dental care) to the extent that the child's health or safety is endangered.[18]

Sexual Abuse

Sexual abuse is defined as acts of sexual assault or sexual exploitation of minors. This category includes a wide spectrum of activities that may occur only once in a child's life or may occur over a period of several years. Specifically, sexual abuse includes the following sexual acts: incest, rape, intercourse, oral-genital contact, fondling, sexual propositions or enticement, indecent exposure, child pornography, and child prostitution. Sexual abuse is most commonly carried out by someone a child knows and does not always involve violence. Males and females, infants and adolescents are all subject to sexual abuse. The abuser may be an adult or another child.[19]

Emotional Maltreatment

Emotional maltreatment is a pattern of acts by the child's caretaker that results in psychological or emotional harm to the child's physical health and development. Patterns of emotional maltreatment include rejection, intimidation, ignoring, ridiculing, threats or isolation.[20]

Reasons for Abuse and Neglect

Child abuse and neglect are universal problems that occur across economic, cultural, and ethnic lines. Research indicates that there are circumstances that increase the likelihood that abuse and neglect may occur in some families. (It is important to remember that the abuser is not always a parent and can be any child care provider, teacher, foster parent, or

anyone responsible for the care of a child.) Circumstances that put a child at high risk of abuse and neglect include:

- Parents and others who have been abused or neglected as children may continue this pattern when raising or caring for children;
- Increased family stress including marital, financial, and employment difficulty;
- Substance abuse in the home;
- Parents and child care providers who lack the skill and knowledge for the role;
- Individual's inability to tolerate frustration and inability to control the impulse to act; or
- Family members and others who feel isolated from family, friends, and community.[21]

Findings in parents that should raise the suspicion of abuse

- Appears to be using drugs or alcohol;
- Has history of criminal activity;
- Tells contradictory stories regarding the child's injury;
- Discourages the child's forming social contact;
- Gives evasive answers to questions;
- Volunteers little or no information regarding injuries;
- Holds unrealistic expectations for the child;
- Directs anger at the child for being injured;
- Makes inappropriate response to the child's crying or pain;
- Demonstrates little touching of the child;
- Has little direct eye contact with the child;
- Shows little tenderness toward the child;
- Shows lack of concern regarding the child's injury;
- Shows little or no interest for the child's treatment;
- Has poor relationships with own parents;
- Was reared in a home where excessive punishment was the norm;
- Tends to be antagonistic, suspicious, and fearful of others;
- Neglects own physical health;
- Has personal or marital problems;

- Appears isolated and transient and seems to have no one to call upon when the stresses of parenthood are overwhelming;
- Grew up in an unloving atmosphere under harsh discipline and feels the right to impose the same conditions on a child.[22]
- Appears to thrive on attention gained from child's injuries/illness (Munchausen Syndrome by Proxy)

The etiology of child abuse is multifactorial. The interrelationships between the child, parent, family, community, and society contribute. Listed below are factors commonly associated with child abuse:

In the Child:

- Prematurity and/or inadequate bonding to mother;
- Developmental or intellectual delay;
- Chronic or acute illness;
- Psychological problems;
- Product of unwanted pregnancy;
- Cause of financial burden; and/or
- Behavior that provokes violence; actions that attract attention.[23]
- Hyperactivity
- Passive, submissive, personality

In the parents:

- Use of violence to resolve conflicts;
- Psychological problems;
- Distorted expectation of child and/or lack of knowledge of growth and development;
- Social isolation or rejection;
- Frustrated dependency needs;
- Power dominance of one parent over the other;
- Single parent home;
- High degree of stress; and/or
- Lack of marketable job skills.[24]
- Substance abuse or other criminal activity

In the Family:

- Unemployment;
- Inadequate housing;
- Loss of family member;
- Frequent relocation of residence;
- Social isolation or rejection by community; and/or
- Lack of extended family support.[25]
- Acceptance of abuse as personal, family business
- Extended family living in home (grandparents, uncles, cousins)
- Combined families living together (step/half relatives)
- Regular exchange of children between divided families

In the Community:

- Environmental stress;
- Overcrowded, poorly supervised neighborhoods;
- Isolation—non-supportive, geographic mobility ;
- Lack of employment opportunities; and/or
- Rejection of weak or dependent families.[26]

In Society:

- Competition-valued rather than cooperation;
- Physical force accepted as method of resolving conflict;
- Societal acceptance of corporal punishment; and/or
- Violence depicted through media.

Usually child abuse is the result of a family crisis or series of crises with some triggering, stressful event. Schools may foster communication, coordination, and cooperation in the community to assist parents in learning how to deal with or resolve stress. The resolution almost always involves counseling for the entire family, not just the abusive person. Treatment generally requires a team effort, including numerous professionals: nurses, physicians, psychologists, social workers, educators, counselors, attorneys, and child care workers.[27]

Assessing for Signs of Abuse and Neglect

Observable Abuse

Observations that should raise the suspicion of abuse:

- Extensive bruises; bruises in various stages of healing; patterns of bruises caused by a particular instrument (belt buckle, wire coat hangers);
- Burn patterns consistent with forced immersion in a hot liquid (distinct boundary line where the burn stops); burn patterns consistent with a spattering by hot liquid; patterns caused by a particular kind of implement (electric iron) or instrument (circular cigarette burns);
- Unexplained lacerations, welts, abrasions, and/or contusions;
- Injuries inconsistent with information offered;
- Suspicious fractures in children less than three years old; sprains and dislocation;
- Multiple, frequent injuries;
- Skull fractures, subdural hemorrhage, and hematoma;
- Human bites;
- Loosened or missing teeth accompanied by lacerated lips;
- Rope marks or burns;
- Poisoning;
- Child described as "different" in physical and emotional makeup; or
- Sexual abuse in any act or acts involving sexual molestation or exploitation, including but not limited to incest, rape, carnal knowledge, sodomy, or unnatural or perverted sexual practices.[28]
- Frequent UTI's, genital bleeding, anal bleeding, pain with bowel movements, vaginal discharge, genital discomfort, genital leisons, ulcers, or sores
- Experiencing cruel treatment

Observable Neglect

Observations that should raise the suspicion of neglect include:

- Malnourished, ill-clad by community norms, dirty, without proper shelter or sleeping arrangements, lacking appropriate health care;
- Unattended, without adequate supervision, abandoned;
- Ill and lacking essential medical attention;
- Expressing destructive and aggressive behavior;
- Irregular in school attendance, truant;
- Exploited, overworked;
- Emotionally disturbed because of continuous friction in the home, marital discord, or mentally ill parents;
- Experiencing cruel treatment;
- Depressed and/or exhibiting suicide gestures, extreme fatigue, anorexia, insomnia, withdrawal, passiveness;
- Denied experiences of being loved, wanted, secure, or worthy; or
- Exposed to unwholesome circumstances.[29]

Child Abuse/Neglect

Child abuse can be one or two isolated incidents or can occur over a prolonged period of time.

Behavioral indicators of abuse:

- Cannot recall how injuries occurred or offers an inconsistent explanation;
- Wary of adults;
- May cringe or flinch if touched unexpectedly;
- Infants may display a vacant stare;
- Extremely aggressive or extremely withdrawn;
- Indiscriminately seeks affection; and/or
- Extremely compliant and/or eager to please.[30]
- Sexualized behavior
- Inappropriate knowledge of sexual terms, language

Patterns that indicate abuse:

- Injuries that are not consistent with explanation;
- Presence of several injuries that are in various stages of healing;
- Presence of various injuries over a period of time;
- Facial injuries in infants and preschool children; and/or
- Injuries inconsistent with the child's age and developmental phase.[31]

The following are guidelines for school personnel to consider for the overall assessment of a suspected case of child abuse:

- A significant factor in distinguishing whether an injury is unintentional or is the result of abuse is an inconsistency between the history of an injury and the injury itself.
- Location of the injury: children are more likely to sustain unintentional injuries on the knees, elbows, shins, and forehead. Injuries located on nonprotuberant areas (such as the back, thighs, genital area, buttocks, back of the legs, or face) are more likely the result of intentional injury.
- Number and frequency of injuries: unless a child has been in a serious accident, the child is unlikely to have a number of injuries concurrently and it is unlikely that the injuries would be at various stages of healing.
- Size and shape of the injury: unintentional injuries rarely have a defined shape. Intentional injuries, such as burns (e.g., from cigarettes, immersion in hot liquids, burns from irons, and ropes) or other objects (e.g., sticks, belts, hairbrushes, and human bite marks), will have a definitive, definable appearance.
- Description of how the injury occurred: unintentional injuries, when described by a child, generally have a reasonable explanation and one that is consistent with the appearance of the injury. Descriptions of injuries by a child that are inconsistent with the presentation are cause for suspicion.
- Consistency of injury with the child's developmental capability: A child presenting with an injury that the child is developmentally or physically incapable of causing (e.g., child is too small to generate a force sufficient to create that type of injury) should be considered for intentional abuse by their child caretaker.

- Behavioral indicators of physical abuse/neglect: school personnel should also observe children for behaviors that may result from intentional physical abuse/neglect by a child's caretaker. Examples include: wariness of physical contact with adults, apprehension when another child cries, fear of his/her parent(s), stated fear of going home or crying when it is time to go, and report of an injury inflicted by a parent.[32]

It is imperative to document suspected child abuse. Information that must be documented includes: the date, time, and name of the person notifying the nurse, name of the child, address, phone number, name of parent or caretaker, description of the incident. Physical and emotional findings related to the abuse must be explicit and well- detailed. Do not rely on memory. Instead, keep notes concerning each finding. The school nurse should attempt to answer the following questions:

- When, where, and how did the "accident" occur?
- In what state of healing is the bruise, laceration, or burn?
- Size and shape of bruise, laceration, or burn, detailed markings on body
- Does the mark(s) appear new or several days/months old?
- Are there other injuries in various stages of healing?
- What part of the body is affected?
- Does the child appear fearful or protective of the parent?
- Were other people present when the incident occurred?
- Are there other siblings in the home? Do they have "hurts" like these?[33]

Mental Abuse/Neglect

Emotional abuse includes all acts of omission or commission, which result in the absence of a nurturing environment for the child. It occurs when the caregiver continually treats the child in such a negative way that the child's concept of "self" is seriously impaired. Emotionally abusive behavior by the caregiver can include constant yelling; demeaning remarks; rejecting, ignoring or isolating the child; or terrorizing the child. Emotional abuse is the most difficult to identify and prove.[34]

There are a variety of behaviors a child may exhibit as a result of mental abuse/neglect. It is important when assessing for this type of abuse to examine specific behaviors of a child as well as develop an overall picture of the child's ability to interact and communicate with children and other adults. When assessing a child for mental

abuse/neglect, it is important to place the behavior within the context of the child's developmental, emotional, and physical age. The following lists particular behaviors and interaction styles that may be indicators of mental abuse or neglect:

- Habit disorders (e.g., biting, sucking, rocking, enuresis, over- or under-eating without physical cause);
- Conduct disorders (e.g., withdrawal, antisocial behavior, such as destructiveness, cruelty, and stealing);
- Neurotic traits (e.g., sleep disorders, speech disorders, inhibition of play)
- Others (e.g., psychoneurotic traits; overly compliant, passive, and undemanding; extremely aggressive, demanding, or angry behavior; over-adaptive behaviors that are either inappropriately adult or infantile; delays in physical, emotional, and intellectual development; attempts at suicide; frequent comments and behavior suggesting low self esteem)[35];
- Severe depression;
- Overly compliant, too well mannered, too neat or clean;
- Extreme attention seeking;
- Displays extreme inhibition in play.[36]

Physical indicators:

- Bed wetting that is non-medical in origin;
- Frequent psychosomatic complaints, headaches, nausea, abdominal pains;
- Child fails to thrive[37].

Sexual Abuse

Sexual assault can be defined as:

- Any unwanted sexual act committed or attempted against a person's will;
- Forced sexual contact;
- An act motivated by the assailant's need for power and control, not a desire for sex;
- A traumatic event with long lasting effects.[38]

Sexual assault includes statutory rape or indecency with a child. According to Chapter 21, Texas Penal Code[39], indecency with a child includes any sexual contact with a child

younger than 17 years (excluding spouses), whether the child is the same or the opposite sex. The definition also includes as indecency, exposing the anus or any part of the genitals, in the known presence of a child, with the intent to arouse or gratify the sexual desire of any person.

Sexual abuse can be physical, verbal or emotional and includes:

- Sexual touching and fondling;
- Oral/genital contact;
- Exposing children to adult sexual activity or pornographic movies and photographs;
- Having children pose, undress or perform in a sexual fashion on film or in person
- "Peeping" into bathrooms or bedrooms to spy on a child;
- Rape or attempted rape[40];
- Sexual interference;
- An invitation to sexually touch;
- Parent or guardian procuring sexual activity from a child;
- Householder permitting sexual activity;
- Exposing genitals to a child;
- Incest[41].

A child that has been a victim of sexual abuse, whether it is a single incident or a long-term pattern of sexual abuse, is unlikely to reveal this information directly to an adult because the child

- is afraid that no one will believe it
- believes he/she will get into trouble
- believes it is his/her fault
- is afraid of the perpetrator.

More than likely, a child will send signals to those around the child that something is wrong. School personnel need to be attuned to the types of clues that may indicate a child is in a sexually abusive situation. The signs may be physical or emotional and/or reflected in developmentally inappropriate behavior by the child.[42]

Sexual abuse involves forcing, tricking, bribing, threatening, or pressuring a child into sexual awareness or activity. The use of physical force is rarely necessary to engage a child in sexual activity because children are trusting and dependent. Sexual abuse is an abuse of power over a child and a violation of a child's right to normal, healthy, trusting relationships. Because most children cannot or do not tell about being sexually abused, it is up to concerned adults to recognize signs of abuse. Physical evidence of abuse is rare. Therefore, we must look for **behavior signs.** These might include:

- Physical complaints;
- Fear or dislike of certain people or places;
- Sleep disturbances;
- Headaches;
- School problems;
- Withdrawal from family, friends, or usual activities;
- Excessive bathing or poor hygiene;
- Return to younger, more babyish behavior;
- Depression;
- Anxiety;
- Discipline problems;
- Running away;
- Eating disorders;
- Passive or overly pleasing behavior;
- Delinquent acts;
- Low self-esteem;
- Self-destructive behavior;
- Hostility or aggression;
- Drug or alcohol problems;
- Unexplained problems with bowel movements
- Sexual activity or pregnancy at an early age;
- Suicide attempts;
- Copying adult sexual behavior;
- Persistent sexual play with other children, themselves, toys, or pets;
- Displaying sexual knowledge, through language or behavior, that is beyond what is normal for their age;
- Unexplained pain, swelling, bleeding, or irritation of the mouth, genital, or anal area; urinary infections; sexually transmitted diseases;

- Hints, indirect comments, or statements about the abuse[43];
- Age-inappropriate sexually explicit drawing and/or descriptions;
- Bizarre, sophisticated, or unusual sexual knowledge;
- Prostitution; or
- Seductive behaviors.

Physical indicators:

- Unusual or excessive itching in the genital or anal area
- Torn, stained, or bloody underwear (may be observed if the child needs bathroom assistance)
- Continually fecally soiled underwear
- Vaginal discharge
- Genital lesions (warts, ulcers, rash, etc.)
- Pregnancy
- Injuries to the genital or anal areas, e.g., bruising, swelling, or infection
- Sexually transmitted infections [44]

The information below has been divided into two age groups: the younger child and the older child. The information of potential signs of sexual abuse is by no means a complete list of the possible behaviors a child might exhibit when involved in a sexual abuse/neglect situation. School personnel may refer to this list as a guideline for further exploration and to classify behaviors they might be seeing in a child. It is strongly recommended that school personnel become familiar with available resources.[45]

Young Child. A young child (i.e., toddlers, preschoolers, early elementary school-age) may have difficulty verbalizing their fears and concerns as well as the actual sexual abuse to which they are being subjected. This is especially true for children with disabilities. The following list summarizes behavioral and physical signs that may be indicators of sexual abuse in the young child.

Behavioral Signs:

- Reports sexual abuse;
- Sleep disturbances, such as fear of falling asleep and nightmares;
- Sudden changes in behavior and/or regressive behavior;

- Lack of inhibition of exhibiting body;
- Detailed and age-inappropriate understanding and verbalization of sexual behavior;
- Highly sexualized play; or
- Sexual acting out with dolls, stuffed animals, or other children
- Inappropriate behavior with peers and adults that is seductive in nature.[46]

Physical Signs:

- Stomach aches;
- Dysuria (painful urination) or enuresis (involuntary urination after the age at which bladder control should have been established);
- Encopresis (involuntary soiling with feces after the age at which control of defecation should have been established);
- Complaints of genital irritation, laceration, abrasion, bleeding, discharge, or infection. (Sexually transmitted infections should be considered in children with anal or genital infection, discharge, or irritation.);
- A gagging response, sore throat, or mouth or throat lesions (as the result of oral-genital contact); or
- Other signs of physical abuse.[47]

Older child. Older children may be able to verbalize and label what is happening to them in a sexually abusive situation; however, feelings of embarrassment, humiliation, guilt, a sense of responsibility, and fear may prevent them from talking with anyone. In fact, like young children, signs of sexual abuse in older children may emerge in regressive or sudden behavioral changes, physical signs of injury, or withdrawal. The following list summarizes behavioral and physical signs that may be indicators of sexual abuse in the older child.

Behavioral Signs:

- Reports sexual abuse;
- Poor relationships with peers. This may take the form of withdrawal from established relationships; an inability to establish new relationships; or aggressive, violent, or sexually promiscuous behavior;
- Sexual abuse of younger children

- Poor self-esteem;
- General feelings of shame or guilt;
- Eating disorders (bulimia and anorexia);
- Excessive concern about homosexuality (especially boys);
- Deterioration in academic performance;
- Role reversal with parent and overly concerned about younger sibling(s);
- Running away;
- Drug abuse; or
- Moderate to severe anxiety or depression.

Physical Signs:

- Attempts at suicide;
- Unexplained vaginal discharge, pregnancy, and/or sexually transmitted infections;
- Bruises and/or bleeding of external genital, vaginal, or anal areas and inner thighs;
- Gagging response, sore throat, or mouth or throat lesions (as the result of oral-genital contact);
- Difficulty sitting or walking; or
- Other signs of physical abuse.[48]

Other information about the child and his/her family is important to incorporate into an evaluation of possible sexual abuse of a child. In a family where there is a history of the following, a suspicion of sexual abuse may be warranted: physical or emotional abuse of the child or other children; alcoholism; isolation of the family as a whole; overly restrictive control by a father of his female children; expectations by parents that children act more like adults; or vague reports by a parent that their child may have been sexually abused by a stranger or a member of their family.

There are situations in which children sexually abuse other children. These are not situations in which the activity is considered to be the normal sexual curiosity that is developmentally appropriate. These are situations in which (1) a child is the victim of another child; (2) violence may be a component; (3) there is a lack of adult supervision that enables this activity to take place; (4) a child is in a caretaker role of another child; and (5) it is highly possible that the child inflicting the abuse is a victim of abuse. These

situations must be examined carefully. Children 12 years and older engaging in repetitive sexual abuse and violence against other children should be referred to law enforcement for court supervision and services.[49]

Often children do not tell anyone about sexual abuse because they:

- Are afraid no one will believe them;
- Worry about getting into trouble or getting a loved one into trouble;
- Were threatened or bribed by the abuser to keep the abuse a secret;
- Blame themselves or believe the abuse is punishment for being “bad”;
- Are too young to put what has happened into words;
- Feel confused by attention and feelings accompanying the abuse;
- Feel too ashamed, or embarrassed to tell.[50]

Silence enables sexual abuse to continue. Silence protects sexual offenders and hurts children who are being abused. Children who have been sexually abused feel many different emotions, including:

Fear

- Of not being believed;
- Of being punnished;
- Of the abuser;
- Of causing trouble;
- Of losing adults important to them;
- Of being taken away from home; and/or
- Of being "different."

Anger

- At the abuser;
- At other adults around them who did not protect them; and/or
- At themselves (feeling as if they caused trouble).

Isolation

- Because "something is wrong with me”;
- Because they feel alone in their experience; and/or
- Because they have trouble talking about the abuse.

Sadness

- About having something taken from them;
- About losing a part of themselves;

- About growing up too fast; and/or
- About being betrayed by someone they trusted.

Guilt

- For not being able to stop the abuse;
- For believing they "consented" to the abuse;
- For "telling"--if they told; and/or
- For keeping the secret--if they did not tell
- For sexual gratification from the abuse (feels good).

Shame

- About being involved in the experience; and/or
- About their bodies' response to the abuse.

Confusion

- Because they may still love the abuser; and/or
- Because their feelings change all the time. [51]

Listening to Children

If a child trusts you enough to tell you about an incident of sexual abuse, you are in an important position to help that child recover. The following suggestions can help you provide positive support.

Do:

- Keep calm. It is important to remember that you are not angry with the child, but at what happened. Children can mistakenly interpret anger or disgust as directed towards them.
- Believe the child. In most circumstances children do not lie about sexual abuse.
- Give positive messages such as “I know you couldn’t help it,” or “I’m proud of you for telling.”
- Explain to the child that he or she is not to blame for what happened.
- Listen to and answer the child’s questions honestly.
- Respect the child’s privacy. Be careful not to discuss the abuse in front of people who do not need to know what happened.
- Document the child’s outcry.
- Be responsible. Report the incident **immediately** to Child Protective Services. They can help protect the child’s safety and provide resources for further help.

- Get help. Get competent professional counseling for the child, even if it's only for a short time.
- Call the sexual assault crisis center nearest you. They can help with counseling for the child.

Do Not:

- Panic or overreact when the child talks about the experience. Children need help and support to make it through this difficult time.
- Pressure the child to talk about or avoid talking about the abuse. Allow the child to talk at her or his own pace. Forcing information can be harmful. Silencing the child will not help her or him to forget.
- Confront the offender in the child's presence. The stress may be harmful. This is a job for the authorities.
- Blame the child. SEXUAL ABUSE IS NEVER THE CHILD'S FAULT![52]

As a victim of sexual assault, the student has a right to:

- Be believed, regardless of the child's relationship to the assailant;
- Reassure child that the medical exam is not painful or overly traumatic;
- If the child is over 18 years of age, may decide for himself/herself if he/she wants a medical evidentiary exam;
- Obtain and review copies of law enforcement crime reports related to the assailant;
- Request that inaccuracies in the crime report, if they exist, be corrected;
- Request that the child's name not be made a matter of public record on the crime report;
- Request that a friend or family member and a rape crisis counselor be present during the medical evidentiary exam;
- Have a friend or family member and a rape crisis counselor be present during law enforcement interviews and court proceedings;
- Sue the assailant in civil court; and
- If the assailant is held to answer in court the child has the right in certain cases to have the assailant tested for the AIDS/HIV virus (contact victim services in the DA's office for information).[53]

Neglect

The task of determining whether a child has been physically, sexually, or emotionally abused is difficult. Even more of a dilemma occurs in trying to make judgment regarding maltreatment or neglect. Cultural norms must be considered though not used as an excuse or justification for maltreatment. Primary consideration must be for the health, welfare, and safety of the child.[54]

Most caregivers do not intend to neglect their children. It usually results from ignorance about appropriate care for children or an ability to plan ahead. Neglect occurs when a caregiver fails to provide basic needs such as adequate food, sleep, safety, supervision, clothing, or medical treatment.

Behavioral indicators:

- Pale, listless, unkempt;
- Frequent absence from school;
- Inappropriate clothing for the weather, dirty clothes;
- Engage in delinquent acts, alcohol/drug abuse; or
- Frequently forgets a lunch

Physical indicators:

- Poor hygiene;
- Unattended physical problems or medical needs, e.g., dental work, glasses; or
- Consistent lack of supervision.[55]

Referrals to Child Protective Services

The child protection program began with the Child Welfare Division created by the Texas Legislature in 1931 as a program within the Texas Board of Control. During the following decades, federal, state, and county participation in services for abused and neglected children gradually increased. The Texas Family Code, created in 1974, gave the Texas Department of Public Welfare more responsibility for services for abused, neglected, truant, and runaway children. Under this code failure to report suspected abuse or neglect of children became a misdemeanor offense.

Child Protective Services' (CPS) goals include protecting children from abuse and neglect, promoting the integrity and stability of families, and providing permanent places to live for children who cannot safely remain with their own families. All reasonable efforts consistent with child safety are made to protect children without removing them from their homes. If preserving the family while maintaining child safety is not possible, CPS may petition the court to remove the child(ren) from their home and place them with substitute caregivers or families. If CPS and the family cannot solve the problems to allow the children to live at home safely, CPS may recommend to the court that the parent-child relationship be terminated and the children placed with other permanent families or caregivers. [56]

Child Protective Services

Service delivery within the CPS program is provided by local staff in 11 PRS regions and through the use of purchased services. CPS uses a combination of family, community, and agency resources to prevent and protect children from further harm. Staff provide a number of services including intake and investigation of reports of child abuse and neglect; services to families and children in their homes; placement of children in substitute care; development and maintenance of foster and adoptive homes; adoption and post-adoption services; and Preparation for Adult Living (PAL) program. Clients are provided a mix of these direct and purchased services based on their individual needs and local resources. All persons are eligible to receive services without regard to income. Children and their families are eligible, beyond the investigation, for services to prevent risk of further abuse/neglect or removal, services to remove children in danger of further risk, or services to reunify families if:

The finding of the investigation is reason-to-believe, which indicates that abuse and neglect occurred, and the case situation meets the state criteria for family based safety services or substitute care placement services; or
significant risk factors are identified and the family appears unable or unwilling to utilize family and community resources to deal with the risk factors in a manner that will ensure the safety of the child(ren) for the foreseeable future.

Reports

Protective and Regulatory Services (PRS) operates a toll-free, statewide telephone reporting system or "hotline" as a method of receiving reports of suspected abuse or neglect. The purpose of the abuse hotline is to provide the public with a way to report:

- Child abuse and neglect;
- The abuse, neglect, and exploitation of aged and disabled adults; and
- The abuse or neglect of persons in MHMR licensed state schools, state hospitals, state centers, and community-based centers when staff in those facilities are alleged perpetrators.

The **Texas Abuse Hotline number is 1-800-252-5400**. Callers in states not bordering Texas may call (512) 834-3784.[57] The fax number for sending in reports of abuse/neglect to Texas Department of Protective and Regulatory Services is (512) 832- 2091.[58] The information needed to file a report (either by fax or phone) includes the name and address of the child, the name and address of the person responsible for care, custody, or welfare of the child, and any other pertinent information concerning the alleged or suspected abuse or neglect.[59]

According to Section 261.101, Family Code, a person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect shall immediately make a report to CPS.[60] If a professional believes that a child has been a victim of physical or sexual abuse or neglect, he or she must file a report within 48 hours after becoming suspicious of the event. A professional is defined as "An individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties…has contact with children. This term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officiers."[61]

There is no exception for professionals whose communications with a child would otherwise be considered privileged.[62] The filing of a report may not be delegated. Unless waived in writing by the person making the report, the identity of an individual making a report is confidential unless disclosure is ordered by a court and has been determined by the court to be (1) essential to the administration of justice; and (2) not likely to endanger the life or safety of the child, the person making the report or any other person.[63] For a complete citation of the laws related to the confidentiality of the person filing a CPS report, consult the legal appendix of this manual. A person who reports or assists in the investigation of a report of child abuse or neglect, other than a person reporting his or her own conduct or reporting in bad faith or with malice, is immune from any civil or criminal liability that might otherwise be incurred or imposed.[64] See also 19 Texas Administrative Code § 61.1051. Failure to report suspected abuse is a class B misdemeanor.[65]

School personnel suspecting child abuse or neglect may use the following steps when reporting such cases:

- The report must first be called into CPS (Child Protective Services) Child Abuse Hotline (1-800-252-5400) or a law enforcement agency should be called immediately.
- Then the report may be made to the building principal who may call the local CPS.
- If physical or sexual abuse is suspected, photographs should be made but not at the school. Photographs can be useless or even harmful to a case in court because the marks can be interpreted as “shadows” due to poor photographic technique. Leave photography to the police, Child Protective Services, or a child abuse clinic. Nurses who have witnessed the evidence of abuse should draw a picture of the marks detailing where they are located, the size of the lesions, and their color.
- Nothing in this handbook is intended to prevent the individual nurse, teacher, or other school related person from reporting directly to the Child Protective Services or to a local law enforcement agency. The law states that it is a misdemeanor not to report suspected child abuse under penalty of a fine or jail sentence, or both. Being a nurse or a teacher and at school does not relieve anyone of this duty.

- School personnel who may be called as witnesses in court on child abuse cases should be permitted to testify without loss of school salary.[66]

When making a report of suspected abuse/neglect have the following information available:

- The name, address, and telephone number of the child and parents or other person(s) responsible for the child's care;
- The child's birth, date, age, sex, and race;
- Names and ages of siblings and what schools or grades they attend;
- Names and ages of other people who live with the child and their relationship to the child;
- As much information as possible about the incident involving the child, especially where, when, and who was present;
- History of prior injuries or maltreatment of the child or siblings if this is the case;
- Any other pertinent information that the school may have available; and
- Reporting person's name, address, and phone number.

When describing an injury (e.g., cut, mark, bruise) be specific:

- Note the exact location on the body.
- Note the size of the mark—estimate in inches or in relation to a common object (e.g., size of a quarter, size of an egg, shape of an iron).
- Note the color of the injury. Injuries often change color with the passage of time. The colors can range from red to black to purple to green and yellow. Note the presence of bruising in multiple areas that may be in various stages of healing.

In general, relate exactly what the child said in the child's own words. Be careful not to interpret what the child said.[67]

Interview With Students

Authorized officials conducting a child abuse investigation shall be permitted to conduct

the required interview with the child at any reasonable time at the child's school.[68]

When interviewing the child:[69]

- Make sure the child is comfortable. Remain calm and reassuring. Do not rush. If the interviewer reacts with shock, anger, or disgust at what the child tells, the child may interpret that he/she is at fault and has done something wrong, and may be unwilling to reveal further information.
- Attempt to gain pertinent information, using open-ended questions.
- Be careful not to plant ideas or interpretations of what happened in the child's mind.
- Explain the purpose of the interviews in language appropriate to the child's developmental level.
- Let the child know the interviewer will be talking to someone who will try to help him or her, without making any promises to the child that cannot be kept.[70]

Once a report is made to CPS

All reports that meet the statutory definitions of abuse and neglect are assigned a priority based on the level of risk and severity of harm to the child. To establish time frames for investigations, reports of child abuse or neglect are classified into one of two priority groups. Intake staff then assign the appropriate priority based upon information available at the time the report is accepted. The supervisor may specify a more exact timeframe for initiating the investigation.[71]

Priority I Reports

Priority I reports include all reports of children who appear to face an immediate risk of abuse or neglect that could result in death or serious harm. These investigations must be initiated within 24 hours of receiving the call.[72]

Priority II Reports

All reports of abuse or neglect that are not assigned as Priority I, are assigned as Priority II. These investigations must be initiated within 10 days of receiving the report.[73]

Investigation

Child Protective Services caseworkers investigate reports of child abuse or neglect in order to determine whether any child in the referred family has been abused or neglected. In addition, caseworkers assess critical areas of individual and family functioning to determine whether any child in the referred family is at risk of abuse or neglect; and initiate immediate services for children who need immediate protection.

To determine whether any child in the family has been abused or neglected and is still at risk of abuse or neglect, the investigative worker may interview family members and appropriate collateral sources. At the end of the investigation, staff must assign a disposition to each allegation identified for the investigation. Dispositions include the following:

- Reason-to-believe. Based on a preponderance of the evidence, staff concludes that abuse or neglect has occurred.

- Ruled-out. Staff determines, based on available information, that it is reasonable to conclude that the abuse or neglect has not occurred.

- Moved. Before staff could draw a conclusion, the persons involved in the allegation moved and could not be located.

- Unable-to-determine. Staff concludes that none of the dispositions specified is appropriate.

- Administrative closure. Information received after a case was assigned for investigation reveals that continued intervention is unwarranted.[74]

The worker must also determine whether there is a reasonable likelihood that a child will be abused or neglected in the foreseeable future. There are two alternatives.

1. The worker concludes that the children are not at risk if:

   (a) No significant risk factors have been identified, and abuse or neglect has not been found to have occurred in the current investigation; or

(b) The family appears willing and able, through use of family and community resources, to deal with risk factors in their lives in such a manner as to ensure the safety of the child(ren) for the foreseeable future.

If the worker concludes that the children are not at risk, then the case may be closed.

2. The worker concludes that the children are at risk of abuse or neglect if:

(a) The worker has identified significant risk factors; and
(b) The family appears unable or unwilling to utilize family and community resources to deal with the risk factors in a manner that will ensure the safety of the child(ren) for the foreseeable future.[75]

If the worker concludes that the children are at risk of abuse or neglect, then the worker may recommend that the case be opened for ongoing safety services or to proceed with civil court action to protect the victim. Actions could include removal of the child(ren) from the home and, possibly, termination of parental rights.

The worker must complete investigation actions within 30 days from the date the report was received by the agency unless the supervisor has approved an extension. All reports must be referred to the appropriate law enforcement agency for possible criminal prosecution.

The Child Protective Services Handbook (CPSH) Section 3000, Family Based Safety Services, emphasizes and clarifies the paramount concern for child safety, health, and protection as a focal point of policy and practice. CPS policy speaks to family stability and safety and the importance of child permanence. The philosophy, goals, and objectives of the program are clearly communicated.

"Family Based Safety Services" is a term that is being utilized to more effectively describe the type of services in CPSH 3000. The term "Safety Services" describes the focus of CPS Family Based Safety Services to families where children are at risk.[76]

In-Home Safety Services

In-home safety services are protective services provided to a family whose children have not been removed from the home. CPS may provide in-home safety services to any family that needs assistance to reduce the likelihood that a child in the family will be abused or neglected in the foreseeable future. There are three levels of in-home safety services: regular, moderate, and intensive. The level of service is determined by the degree of the risk of removal. Any of these services may be provided directly or through contracts.

Regular in-home safety services are protective and support services provided to a family whose children are not in a court-ordered placement. CPS may provide these services to any family who needs CPS assistance to reduce the likelihood that a child in the family will be abused or neglected in the foreseeable future.

Moderate in-home safety services are a form of intensive services provided to families who need assistance to protect a child from abuse or neglect in the foreseeable future. Families receiving moderate services have high risk of abuse or neglect and the alternative to providing moderate services may be to remove the child from the home.

Intensive in-home safety services are provided to families that need intensive assistance to protect a child from abuse or neglect in the immediate or short-term future. The alternative to providing intensive services is to remove the child from the home.[77]

Reunification Safety Services

CPS provides reunification safety services to families whose children are returning home at the end of court-ordered placements in substitute care. The term does not describe the services that CPS provides to families over the general course of a child's stay in substitute care, even though those services are usually directed toward family reunification. The purpose of the services is to provide support to the family and the child during the child's transition from living in substitute care to living at home. There are three levels of reunification safety services: regular, intensive early, and intensive family reunification safety services. Any of these services may be provided directly or through contracts.[78]

CPS provides **regular reunification safety services** to families whose children are returning home at the end of court-ordered placements in substitute care. The purpose of the services is to provide support to the family and the child during the child's transition from living in substitute care to living at home.[79]

Intensive early reunification safety services are provided to families when a child has been in substitute care no longer than 30 days. In many of these cases the children are returned home by the "14-Day Show Cause Hearing." Risk factors are high in these cases and intensive support services are needed.[80]

CPS provides **intensive family reunification safety services** to families whose children have been placed in substitute care for a 30-day period of time or longer. Depending on the length of time a child has been in substitute care, the family may need various levels of support to rebuild the parent-child relationship. These families should be provided with a continuum of services through community agencies, CPS services, and extended family support. These resources are used to assist the child and family through the reunification process.[81]

Substitute Care

Substitute Care is a reasonable alternative for keeping the child safe from abuse and neglect. If preserving the family is not possible, CPS may petition the court to remove the child from the home. The courts are required to place the child with an appropriate non-custodial parent or relative, if they are willing and able to care for them.

If not, the court may place the child with close family friends who have been given temporary legal possession of the child. Otherwise, the court may allow the department to place the child temporarily in foster care with a foster family, foster group-home, or residential group-care facility.

If CPS and the family cannot solve the problems to allow the child(ren) to return and live at home safely, CPS may recommend to the court that the parent-child relationship be terminated and the child(ren) placed with a permanent family or caregiver.

The permanency plan for every child in CPS managing conservatorship must be directed toward one of the following goals: family preservation, family reunification, permanent

placement with relatives through adoption or conservatorship adoption by non-relatives, an alternative form of long-term care, or adult living. [82]

Foster Care

When children must be placed outside their home, and there is not an appropriate non-custodial parent or relative willing and able to care for them and there are not any close family friends to whom the court can give temporary legal possession, the court will allow the department to place the child temporarily in a foster care setting that is one of the following:

> A foster family-home or group-home that has been either trained and verified by CPS, licensed by PRS Office of Child-Care Licensing (CCL), or verified by a CCL-licensed child-placing agency; a residential group-care facility that has been licensed by CCL; or a facility under the authority of another state agency.

Foster care is meant to be a temporary situation for a child until a permanent living arrangement can be obtained. The foster care placement may become the permanent placement for the child, either as an adoptive home, as a home that has taken managing conservatorship of the child, or, if there are no other preferable options available, as a long-term foster care placement.

Though the department strives to ensure quality services for children placed in foster care, such children may experience various placement changes over time because of a child's behavioral or medical concerns, lack of permanency commitments, licensing standards violations, court rulings, or changes in the foster home/facility or improvement of the child's overall functioning requiring less restrictive care.[83]

If a Report of Suspected Child Abuse or Neglect is Not Accepted by Child Protective Services

If the criteria for investigation are not met, Child Protective Services will not pursue the report. When CPS does not investigate a report, it usually means that the situation does not meet the legal definition of abuse/neglect, law enforcement has the responsibility to investigate, or the family's problems can be more effectively addressed by a different type of service. If the person reporting the abuse disagrees with the decision not to pursue the investigation, then the school personnel responsible for the reporting of abuse/neglect situations may discuss their concerns with the CPS supervisor.

If the situation is labeled "unfounded," it does not mean that the family may not be having problems. It just means that according to the law and the Department of Social Services policy the situation cannot be labeled as abusive/neglectful. The social worker may recommend a course of action, including other community-based services available (e.g., mental health treatment, substance abuse services, court services, and shelter care).[84]

Role of the School Nurse

The school may be instrumental in providing assistance to the family to prevent the abuse or neglect of children. Such prevention programs may be in the form of support groups and educational programs as well as students utilizing the many programs developed for awareness and education of family problems and situations.

Professionals who have had unsatisfactory reporting experiences in the past may be reluctant to report a second case of abuse/neglect to the local Department of Social Services. It is possible that the experience the professional had may have been unsatisfactory and that they may have developed a distrust of the system for investigating abuse/neglect situations, feeling that nothing will be done again. Professionals must keep in mind that they are legally bound to report a case of suspected child abuse. In addition, if the incident is not reported nothing will be done. Abused and neglected children cannot be protected unless they are first identified, and the key to identification is reporting.[85]

Awareness of child abuse and neglect is a first step toward prevention and early intervention. The school nurse should take a leading role in promoting awareness by providing training for staff members on early recognition of abuse and neglect, developing curricula for parenting or family life classes for students, and working with other professional and community organizations to intervene with abusive families and to support research, prevention, and follow-up activities.

It is the school nurse's professional responsibility to identify, report, and follow up on suspected cases of child abuse or neglect. As the school's primary health care provider on site, the school nurse is a resource and model for other staff members in the school who might suspect a case of child abuse or neglect.

It is the position of the National Association of School Nurses that the school nurse initiate, participate, and/or cooperate in, school and community activities designed to prevent, identify, and/or treat, the problem of child abuse and neglect in any form, as well as to provide early intervention and follow-up. NASN supports legislation to assist in prevention and treatment programs, and encourages public and private agencies to develop programs that increase the availability of information on health consequences of child abuse and neglect.[86]

Referrals To Other Health Care Providers

Due to “new morbidities,” there is an increased need for referrals to other health care providers. These "new morbidities" include an increase in chronic health conditions, such as asthma, allergies and diabetes, addictions, teen pregnancies, HIV/AIDS, STIs, suicide, auto accidents and injuries or deaths from violent acts. Many of these health problems are the result of poverty, homelessness, poor nutrition, lack of exercise, smoking, early and/or unprotected sexual activity, substance abuse, stress and depression. The intensity and types of school health programs to address these health issues vary from one state to another and within the same state.[87]

Many situations arise during school in which the school nurse decides that a student needs to be referred to another health care provider for further assessment or management of a condition. Students may need to be referred to a primary care provider, a counselor, or a social worker or they may need to be put in touch with providers of other specialized services such as dentistry, ophthalmology, audiology or, speech and language therapy. The school nurse can utilize case management skills and resources to ensure that a child is connected to the proper provider, and that the family is prepared to manage possible barriers to the referral such as transportation, financial barriers, or language barriers. There are as well, certain laws governing the referral process and parents’ right to refuse a referral.

Primary Health Care Providers

Consistent developmental and medical surveillance is crucial for children and adolescents. Many children who present to the school nurse have neither a medical home nor primary care provider (PCP). The school nurse can be instrumental in assisting families to identify providers in the community that can meet the needs of the family. If a child has medical insurance, the school nurse can assist the family in deciding on a PCP based on the providers that are members of the plan. If the family is without medical insurance, the school nurse can direct them to free or sliding-scale clinics in the community, or to the nearest School-Based Health Center. When a child presents to the school nurse with a problem that should be addressed the same day, the nurse can direct the family to the most appropriate urgent care center.

The following information is offered for the school nurse caring for a family without health insurance.

TexCare Partnership

TexCare Partnership offers a comprehensive benefits package with a full range of coverage, including regular checkups, immunizations, prescription drugs, eyeglasses, laboratory tests, X-rays, hospital visits, dental care and mental health care – from a broad choice of doctors. For additional information or to apply for health insurance, please go to the TexCare Partnership website at www.texcarepartnership.com/CHIP-About-TexCarePartnership.htm.

TexCare Partnership offers two separate children's health insurance programs: Children's Health Insurance Plan and Medicaid. Both programs provide health insurance for children at a price that fits the budgets of Texas families. Rates are flexible and are based on the number of people in your family and your family's income and expenses. Children do not have to be US citizens to apply.

TexCare Partnership also determines eligibility for the State Kids Insurance Program – SKIP. State employees may qualify for an insurance supplement for dependent children under age 19 years. SKIP supplements are covered through the state insurance program.[88]

Children's Health Insurance Plan

Designed for families who earn too much money to qualify for Medicaid health care, yet cannot afford to buy private insurance. Parents may have jobs that do not offer health insurance or the insurance offered may be too expensive for the family.

CHIP insurance will solve this cost problem for many Texas families. In CHIP, many families will only pay an annual fee of $15 to cover all their children in the plan. Higher-income families will pay monthly premiums of $15 or $18, which covers all children in the family. Most families also will have co-payments for doctor visits, prescription drugs, and emergency care.

CHIP is offered by private health plans. CHIP health care coverage is comparable to that provided to families who get their insurance through employers. The CHIP benefits package has been designed specifically to meet the needs of children.

CHIP covers services such as hospital care, surgery, x-rays, therapies, prescription drugs, mental health and substance abuse treatment, emergency services, eye tests and glasses, dental care, and regular health check-ups and vaccinations.

Children who enroll in CHIP receive 12 months of continuous coverage. Families must re-enroll their children once a year.

To Qualify For CHIP A Child Must Be:

- A Texas resident;
- A US citizen or legal permanent resident (the citizenship or immigration status of the parents does not affect the child(ren)'s eligibility and is not reported on the application form);
- Under age 19;
- Be uninsured for at least 90 days (although there are several exceptions to this requirement); and
- Living in a family that meets CHIP Income Requirements.

Call 1-877-543-7669 or 1-800-647-6558 to ask questions about CHIP or to apply over the phone. Operators work between 9 a.m. and 9 p.m. M-F and until 3 p.m. (Central Time) on Saturdays, except federal holidays.[89]

Medicaid

Medicaid health insurance is provided at no cost to qualifying children.
Children's health care benefits under Medicaid are extensive and often are even better than benefits packages offered by private employers. Medicaid emphasizes preventive health care so that children's health problems can be caught early, or prevented altogether.

Once qualified for Medicaid, the child continues to receive coverage until a change occurs in the child's or the family's situation that would cause disqualification. The child's situation is checked periodically, usually once every six months, possibly more often, to determine if the child still qualifies for Medicaid coverage.

To Qualify For Medicaid Coverage A Child Must Be:

- A Texas resident;
- A U.S. citizen or a certain category of legal residence (this requirement may not apply in medical emergencies);
- Under age 19;
- Living in a family with assets below established levels. Assets do not include the family's home or personal property; however, all or part of the value of a vehicle may count in certain situations; and
- Living in a family able to meet Medicaid income requirements. (Most types of income are counted. Deductions for work-related expenses and dependent care expenses are allowed when figuring income eligibility).[90]

The primary care information for community, rural, migrant health main number is 1-703-821-8955x248.

Emotional

Mental well-being is determined by the inter-relationship of physical, environmental, social, and psychological factors. Mental health issues have become critical and of concern in today's society. One in five children has a diagnosable mental, emotional, or behavioral disorder; one in ten suffers from a serious emotional disorder. Yet few receive mental health services (Center for Mental Health Services (CMHS), 1999). Mental health problems can negatively impact students' ability to learn, function and interact within families, schools and communities and result in financial and social cost to society.

School nurses are members of the comprehensive team necessary to provide quality interventions for affected students. They work with students, parents, school personnel, and medical and mental health communities to assess immediate and long-term mental health needs, to initiate appropriate action to meet these needs, to assure follow-up, and to provide on-going support once a treatment plan is in place and students are in school.

The school nurse provides a unique and essential contribution to the emotional climate within the educational environment. School nurses, as members of the school interdisciplinary team that may involve counselors, social workers, psychologists, and educators, have the unique ability to address problems holistically, including physical, emotional, and social perspectives. School nurses are professionally prepared, know and understand the developmental continuum and needs of students and their families, and are often viewed as "trusted individuals" by students, parents and school personnel. School nurses are required, by the scope of nursing practice, to provide education and counseling to students about health issues, including mental health issues.
It is the position of the National Association of School Nurses that school nurses have expertise to meet the needs of school age youth by:

- Assisting students to develop problem-solving techniques, coping skills, anger and conflict management skills, and a positive self-image that will facilitate realization of student potential;
- Providing on-going assessment, intervention and follow-up of the physical and mental health of the school community;
- Providing education and resources to enable school staff to recognize signs and symptoms of potential mental health problems and to model positive identity and/or behavior;
- Being active members of curriculum committees, child-study teams, student assistance teams, crisis intervention teams, etc.;
- Being resource people available to provide medical information to school staff, referral information to families and coordination between school, family and health care providers; and
- Providing monitoring and evaluation of treatment plans and collaboration with health care providers to optimize treatment.[91]

According to Section 38.010, Education Code, "Outside Counselors", a school district or school employee may not refer a student to an outside counselor for care unless the following steps have been taken:

- The district must obtain prior written consent for the referral from the student's parent;
- The district must disclose to the student's parent any relationship between the district and the outside counselor;
- The district must inform the student and the student's parent of any alternative public or private source of care or treatment reasonably available in the area;
- The referral requires the approval of appropriate school district personnel before a student may be referred for care or treatment or before a referral is suggested as being warranted; and
- Any disclosure of a student record that violates state or federal law is prohibited (See Chapter 3, *School Health Services,* and Appendix A, *Legal Index,* of this manual for a more in-depth discussion of laws related to access to student records.)

(b) In this section, "parent" includes a managing conservator or guardian.

In regards to mental health, §38.011.School-Based Health Centers states the following:

(f) If it is determined that a student is in need of a referral for mental health services, the staff of the center shall notify the person whose consent is required under Subsection (c) verbally and in writing of the basis for the referral. The referral may not be provided unless the person provides written consent for the type of service to be provided and provides specific written consent for each treatment occasion.

For a school-based health center, one should follow the statutes included in the Education Code, Sections38.057 and 38.053. These state the following:

"Sec.38.057. (a) Identification of Health-Related Concerns. The staff of a school-based health center and the person whose consent is obtained under Section 38.053 shall jointly identify any health-related concerns of a student that may be interfering with the student's well-being or ability to succeed in school. (b) If it is determined that a student

is in need of a referral for mental health services, the staff of the center shall notify the person whose consent is required under Section 38.052 verbally and in writing of the basis for the referral. The referral may not be provided unless the person provides written consent for the type of service to be provided and provides specific written consent for each treatment occasion."

Referrals to services for Mental Health

See Chapter 6, Exhibit 4 lists free resources for mental health for children and adolescents.

The Texas Department of Mental Health and Mental Retardation (TDMHMR) is another resource for children and families who have few resources and need medication for psychiatric disorders. TDMHMR accepts children and adolescents as one of their primary focus populations[92]: Children and adolescents under age 18 with a diagnosis of mental illness who exhibit severe emotional or social disabilities which are life-threatening or require prolonged intervention.

Individuals access services through the mental health or mental retardation authority for their county, which links people with appropriate service providers. To learn more about services in your area, visit the www.TDMHMR Directory of Services web page.

Many communities provide mental health services through community clinics, or private organizations. The school nurse should try to locate these resources for the children in the school district.

Social Well-Being

The federal, state and local governments provide many programs designed to help meet social well-being and nutritional needs of low-income citizens and their families.

To receive foods stamps everyone in a household must have or apply for a Social Security number, and be in one of the following categories:

- Citizens or nationals of the United States;
- Legally admitted for permanent residence and have a total of 40 qualifying work credits; (work credits earned by a spouse or parent may count toward the 40 credits, but only for Supplemental Security Income— SSI— eligibility purposes);
- Certain noncitizens who are legally admitted for permanent residence and who are active duty members, or who are honorably discharged veterans of the U.S. armed forces, their spouses and unmarried dependent children; or
- Certain American Indians who are born outside the U.S. armed forces, their spouses and federally recognized Indian tribes.
- Certain other noncitizens may be eligible for seven years after: the date of admission as a refugee under section 207 of the Immigration and Nationality Act (INA); the date granted asylum under section 208 of the INA; or the date deportation is withheld under section 243(h) of the INA, as in effect before April 1, 1997, or the date removal has been withheld under Section 241(b)(3) of the INA; the date admitted as an Amerasian immigrant under section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act, 1988;or the date granted status as a Cuban or Haitian entrant as defined in section 501 (e) of the Refugee Education Assistance Act of 1980.

Most people between the ages of 18 and 60 must register for work. Many people may be required to participate in an employment and training program. Some college students also may be eligible. Generally, a household can't have more than $2,000 in resources. But, if a household includes a person age 60 or older, the limit is $3,000. Resources include cash, bank accounts and other property.

Not all resources are included in assessment of resources. For example, a primary residence and the land it occupies are not included. Vehicles may be included but it depends on whether they are used for work, transportation to work, or pleasure.

Most households also must meet an income limit after certain deductions have been subtracted. Extra deductions are given for households which include a person age 60 or older or disabled. The income limits vary by household size and change each year.

Note: If everyone in a household receives SSI or Aid to Families with Dependent Children (AFDC), additional resource or income limits do not have to be met.

If a household is eligible, the amount of food stamps will depend on monthly household income and expenses for such things as:

- Mortgage or rent;
- Utility costs; and
- Child and/or elderly family member care costs needed to allow someone to work.

The U.S. Department of Agriculture offers a toll free number for food stamp information at 1-800-221-5689. Food stamp applications are available at any Social Security office. If a family buys and prepares their own food for themselves and has applied for or receives SSI payments, the Social Security office will help them fill out the food stamp application and will send it to the food stamp office.

All others must take or send the food stamp application to the local food stamp office. Or, they can take it to the Social Security office if a food stamp worker is there.

When applying a person should have:

- Some identification that shows name and address;
- Proof of earnings or other income, such as social security or ssi benefits, or a
- Pension, for each member of the household;
- Proof of how much is spent for child care;
- Rent receipts or proof of mortgage payments;

- Records of utility costs; and
- Medical bills for members of household age 60 or over and for those getting social security or SSI benefits because of disability

Persons should find out if they are eligible within 30 days. If they do not hear by that time, have the person call or visit the food stamp office.

If a person is homeless, there are special provisions to help them receive food stamps:

- Claims are given priority handling;
- Eligibility will be based solely on circumstances;
- If application is made after the 15th of the month, they can get two months' worth of food stamps as soon as the claim is approved; and they may use food stamps at approved eating facilities, such as some “soup kitchens” and certain restaurants.

Persons are considered homeless if they don't have a fixed regular nighttime residence or the primary nighttime residence is a temporary accommodation in:

- A supervised shelter;
- A halfway house;
- The residence of another person; or
- A place not designed for regular sleeping, such as a hallway, bus station or lobby.

Other Nutrition Programs Available

Many of these programs also are intended to improve the health and eating habits of the nation's children.

Special Supplemental Food Program For Women, Infants and Children (WIC)

The WIC program provides nutritious foods that add to the diets of pregnant and nursing women, infants and children under five years of age. It also provides nutrition education and access to health services. WIC is administered by the Department of Agriculture

through the state health departments. Eligibility is based on income and nutritional risk as determined by a health professional.[93]

A list of other helpful contacts include:

- Center For Disease Control and Prevention: www.cdc.gov/

Public Inquiries
(404) 639-3534 or (800) 311-3435
Centers for Disease
Control and Prevention
1600 Clifton Rd.
Atlanta, GA 30333
U.S.A
(404) 639-3311

- American Academy of Pediatrics: www.aap.org/

National Headquarters:
The American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1098
USA
847/434-4000
847/434-8000 (Fax)

or

Washington, DC Office:
The American Academy of Pediatrics
Department of Federal Affairs
601 13th Street, NW
Suite 400 North
Washington, DC 20005 USA
202/347-8600
202/393-6137 (Fax)

- Texas Nurses Association: www.texasnurses.org/

The Texas Nurses Association or Texas Nurses Foundation
7600 Burnet Road, Suite 440, Austin, TX 78757
TNA: 512.452.0645
TNF: 512.453.7015
FAX: 512.452.0648
e-mail: tna@texasnurses.org

- Texas Department of Health
  - www.tdh.state.tx.us/

Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199
(512)458-7111
TDD (512)458-7708

- Texas Association of School Nurses
  www.tasn.org/

E-mail: info@tasn.org
Mail: TASN
3700 Forums ste. 201
Flower Mound, TX 75028

- Texas Education Agency
  www.tea.state.tx.us/

  Texas Education Agency
  1701 North Congress Ave
  Austin, TX 78701-1494
  (512) 463-9734

Nursing Liaison Services to Homebound Students

Some children, because of acute or chronic medical problems, are unable to attend school on a regular basis. These problems include a diverse set of maladies, such as recovery from surgery, trauma, prolonged recuperation from medical illness, chronic disease, and mental health conditions. Documentation of the student's inability to attend school should be provided by the primary care provider. This may require the assistance of the appropriate subspecialist, and, in the case of mental health issues, input from the psychiatrist, psychologist, or mental health counselor. The primary care provider must,

in collaboration with the school district homebound education team, specify the anticipated duration of the homebound instruction. The need for homebound instruction should be reviewed at the end of that period. While medical and nursing care will be provided by a private physician or home health service, it is the job of the school nurse to serve as a liaison between the family, the school, and the medical team. The nurse will also assist in planning for the child's return to school.[94]

Homebound instruction is governed by federal and state laws, but implementation may vary not only from state to state, but also from one school district to another. Homebound instruction is meant for acute or catastrophic health problems that confine a child or adolescent to home or hospital for a prolonged but defined period of time and is not intended to relieve the school or parent of the responsibility for providing education for the child in the least restrictive environment. This is defined by the Individuals with Disabilities Education Act (IDEA) of 1997 and Section 504 of the Rehabilitation Act of 1973. The responsibility of public schools is further defined by the 1999 Supreme Court ruling in Cedar Rapids Community School District v Garrett F. In 1999, the IDEA was amended "to assure that all children with disabilities have available to them . . . a free appropriate public education which emphasizes special education and related services designed to meet their unique needs"20 U.S.C. §1400 (c).

Clearly defined school policies for non-school based instruction should be established. Absence from school for any period will disrupt the educational process and should prompt the school administrator, school nurse, child's primary physician, or child's parent to request non-school-based instruction. This non-school-based instruction should be considered as soon as possible for a child who may be absent for a prolonged period (e.g., cystic fibrosis) or for a child repeatedly absent for brief periods (e.g., hospitalization for acute asthma). Information should be exchanged among the school, parents, and primary care physician to select the most appropriate type of non-school-based instruction for the child. For the hospitalized child, educational goals should be addressed in the discharge plan.

The school should identify a team to review the pertinent data for the child with the family and appropriate school administrators. This team could be linked to the IEP (individual education plan) team required by IDEA. Discussions should include review of relevant medical data, consideration of all educational options, a specific duration for services, and a plan for returning the child to the classroom. The decision for non-

school-based instruction must be reviewed yearly by the school team with the goal of maintaining academic progress and returning the child to school as soon as possible.

Frequent or intermittent absences attributable to recurring illness, such as recurrent asthma or sickle cell vaso-occlusive crises, present a situation requiring frequent communication among parents, school administrators, and the primary care physician. This situation needs to be anticipated, and plans should be made, because there is often a delay between requests for and implementation of non-school-based instruction.

Other important issues include the following: the need to assess community resources to support return to school (transportation), the option of part-time school attendance, and in-school resources needed to allow an early return to school.

The school nurse will be notified by school authorities when a student has been recommended for homebound instruction. She may perform the following functions in relation to homebound students:[95]

- Contact the family and student by telephone and home visits to assist the family in the utilization of appropriate community services.
- Assist school personnel in the interpretation of medical information.
- Assist the student in making the transition from home to school.

Following a student's illness, the school nurse will examine the student to determine if they need to remain at home or if they are in a condition to return to the school environment.

Any student in grades K-12 may be considered for homebound instruction if it appears that the student will be absent from school for fifteen days or more due to a physical illness, mental health treatment, or pregnancy. A request for homebound services during mental health treatment may be signed by a mental health professional. If a student is to receive home-schooling for medical reasons, the school nurse sends a Physician's Approval form to the student's doctor to confirm the need for homebound instruction. This may be done by mail or by fax. If the school nurse receives permission verbally over the telephone, this must be followed up with a signed statement from the physician.[96]

The school nurse works as a team member with the other school authorities to understand student health care needs and implement care plans. He/she acts as a liaison to help link school and community programs and provide case management for students and their Individualized Health Care Plans.

Home Visits

For children who are unable to attend school, education should be available in an alternative setting, such as rehabilitation center, hospital, or the home. If special services, such as transportation, are provided, most children with medically fragile conditions or who require technological support can attend school. For these children, placement in the least restrictive environment that is medically feasible is the best way to normalize the learning environment.[97]

Historically, school nurses have been making home visits since 1902, when they introduced home visits for sanitary inspection. School nurse roles are evolving in the home, and it is suggestive that school nurses can do the following:

- Serves as liaisons between home and school regarding health concerns;
- Make home visits;
- Record health histories;
- Assess long-term illnesses.
- Implement case management within the school setting;
- Participate in parent-nurse conferences;
- Provide information and referral to community resources;
- Involved with parent groups; and
- Provide activities for health promotion and education.[98]

Home visits made by members of the interdisciplinary team offer an excellent opportunity to foster communication between school and home. Advantages include:

- Convenience for the family;
- Option for those families unwilling or unable to travel;
- Family control of the setting and the potential for active participation in meeting the student's health needs;

- The opportunity to gain a more accurate assessment of the student's family structure and behavior in the natural environment; and
- The opportunity to make observations of the home environment and to identify both barriers and support for reaching family health promotion goals.

During home visits, school health personnel can:

- Establish rapport with the student's family support system;
- Assess family strengths and needs, including limitations and barriers to the student's achievements, the student's need for community health resources, and the student's behavior and reactions to home situations;
- In partnership with the family, plan school health services that promote and support family goals to maximize functional capabilities, including the student's self-care, independence, and future school attendance; and
- Provide for family/student participation in health promotion, maintenance, and restoration, including providing information needed to make decisions and choices about using health care resources.

In preparing for the home visit, school health personnel should:

- Review available school and health records prior to home visit;
- Review current health care plans;
- Identify objectives for the visit;
- Contact student's health care provider, when appropriate, for questions and/or concerns;
- Plan time of visits to optimize safety and effectiveness;
- Make an appointment in advance of the visit;
- Log in and out at school office, noting the telephone number and address of the home to be visited, time of departure, and expected return;
- Wear identification (e.g., name badge); and
- Avoid going alone to neighborhoods known to be dangerous.

During the home visit, school health personnel should:

- Explain purpose of the visit;

- Observe the home and surrounding environment, significant sociocultural influences, and interaction of family members;
- Identify health care needs/problems, based on subjective and objective data, and involve the family members in the process;
- List problems in order of importance in accordance with family perceptions;
- Discuss alternative solutions and available community resources;
- Make referrals as necessary to appropriate health care providers;
- Assist in the development of a plan for the appropriate interventions and establish a time to evaluate the effectiveness of the plan.
- Share the plan with appropriate persons involved in the health care of the student.

After the home visit, school health personnel should record and document:

- Subjective and objective data, problems identified, and plan of action including time line for achieving planned interventions; and
- Future plans and recommendations for home visits.[99]

MEDICAL REFERRAL/FOLLOW-UP

Dear Parent/guardian:

Please take your child and this referral note to your doctor/dentist for an exam and advice about the possible health problem described below. Let me know if you need help getting a doctor or dentist or help to follow the advice.

Estimados Padres:

Favor de llevar a su hijo(a) y esta nota de referencia con su doctor/dentista para un examen y un consejo professional sobre el posible problema de salud descrito a continuación. Avíseme si necesita ayuda para conseguir doctor/dentista o para seguir el consejo professional.

_____, RN
(Enfermera titulada)

_____ School
(Escuela)

_____ Scheduled
(Horario)

_____ School Phone
(Teléfono de la escuela)

At other times I can be reached by calling _____

Dear Doctor: Date: _____

I saw or reviewed information on (student)_____ (birthdate) _____ (grade) _____.

I recommended medical evaluation or dental care for the following reasons:

Subjective report and/or history: _____

_____

_____

Objective: _____

_____

_____

Please share your impressions about the severity and expected outcome of the condition(s) and your recommendations on limited school attendance or activity, your orders for any specialized care procedure, class adaptations or other actions for this student's safety and health.

Impression: _____

_____

Summary of treatment plan: _____

_____

Scheduled return visit? _____ If yes, when? _____
Recommendations for school: _____

_____

Physical Education limits/recommendations: _____

_____

What, if any, monitoring by the school nurse is needed and to whom are reports given? _____

_____

Name of Doctor _____ Signature _____
(PRINT/STAMPED)

Address _____ Telephone _____ Date _____

Please return this form to the school nurse**. You may ask the parent or student to carry it or mail it to me at** _____

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